

EXHIBIT F

EDMUND G. BROWN JR.
Attorney General of the State of California
DAVID S. CHANEY
Chief Assistant Attorney General
ROCHELLE C. EAST - 183792
Senior Assistant Attorney General
JONATHAN L. WOLFF - 193479
Supervising Deputy Attorney General
LISA A. TILLMAN - 126424
Deputy Attorney General
KYLE A. LEWIS - 201041
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5677
Facsimile: (415) 703-5843
lisa.tillman@doj.ca.gov
kyle.lewis@doj.ca.gov

Attorneys for Defendants

HANSON BRIDGETT LLP
JERROLD C. SCHAEFER - 39374
PAUL B. MELLO - 179755
S. ANNE JOHNSON - 197415
SAMANTHA TAMA - 240280
RENJU P. JACOB - 242388
425 Market Street, 26th Floor
San Francisco, CA 94105
Telephone: (415) 777-3200
Facsimile: (415) 541-9366
jschaefer@hansonbridgett.com
pmello@hansonbridgett.com
stama@hansonbridgett.com
rjacob@hansonbridgett.com

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
AND THE NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al.,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,
Defendants.

No. 2:90-cv-00520 LKK JFM P

THREE-JUDGE COURT

MARCIANO PLATA, et al.,
Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,
Defendants.

No. C01-1351 TEH

THREE-JUDGE COURT

**DECLARATION OF LISA TILLMAN IN
SUPPORT OF DEFENDANTS' MOTIONS
FOR DISMISSAL OR, ALTERNATIVELY,
FOR SUMMARY JUDGMENT OR
SUMMARY ADJUDICATION**

To: Three-Judge Panel

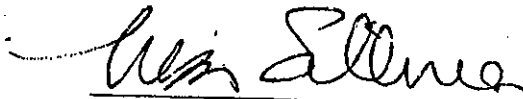
1 I, Lisa Tillman, declare as follows:

2 1. I am an attorney licensed to practice in the State of California and admitted to the
3 Northern and Eastern Districts of the United States District Court of California. I am employed
4 as a Deputy Attorney General of the Office of the Attorney General, counsel of record for the
5 Defendants in this matter.

6 2. I have personal knowledge of the facts stated in this declaration, and if called upon
7 to testify to those facts, would and could do so competently. I submit this declaration in support
8 of Defendants' motions for dismissal, or alternatively, motion for summary judgment or summary
9 adjudication.

10 3. On July 16, 2008, I sent via email the *Coleman* Defendants' July 2008 mental
11 health bed plan to Special Master Lopes for review and approval. Plaintiffs' counsel were copied
12 on that email and its attached mental health bed plan. Attached as Exhibit A is a true and correct
13 copy of that July 2008 mental health bed plan.

14 I declare under penalty of perjury that the foregoing is true and correct. Executed in
15 Sacramento, California, on September 15, 2008.

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17 Lisa Tillman
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EXHIBIT A

FOR SUBMISSION TO THE COLEMAN SPECIAL MASTER
California Department of Corrections and Rehabilitation's
Mental Health Bed Plan
July 16, 2008

I. Overview

A. Background

On December 19, 2006, the California Department of Corrections and Rehabilitation (CDCR) submitted to the *Coleman* Court the Mental Health Bed Plan – December 2006, which was a plan to meet through construction and reorganization, the treatment and office space, outpatient housing and inpatient bed needs for the projected mental health inmate-patient population. In reply to the Special Master's response to that plan, in August 2007, CDCR submitted a supplemental bed plan that included more detail regarding the CDCR's plan to assume responsibility for treating inmate-patients in acute and intermediate care (inpatient) settings. By order on October 17, 2007, the *Coleman* Court approved the Special Master's report and approved the August 2007 Supplemental Bed Plan with the requirement for further planning on the issues identified below.

Since the August 2007 Supplemental Bed Plan was approved, the CDCR, the Department of Mental Health (DMH), the *Coleman* Special Master and the *Plata* Medical Receiver (Receiver) have been working in partnership to implement the plan in conjunction with the Receiver's facility plan. Intensive collaborative, programmatic and preliminary design planning efforts were commenced and are continuing. Adjunctive to the collaboration effort, the CDCR has continued to pursue the planning processes, including the Capital Outlay funding process, to implement the "Consolidated Care Centers" as outlined in the Supplemental Bed Plan.

On February 26, 2008, the *Coleman*, *Plata*, *Perez* and *Armstrong* courts approved the "construction agreement" for collaborative "construction of approximately 5,000 additional CDCR medical beds and approximately 5,000 CDCR mental health beds." The construction agreement provides that the Receiver "will assume leadership responsibility for each of the...projects." Additionally, the order states, "Given the significant need to coordinate the long-term treatment and care of mentally ill patients who also have serious medical problems, there exist both strong patient care and fiscal incentive to plan, design, and construct health care facilities that will effectuate coordinated medical and mental health treatment. Therefore participation by *Coleman* representatives in this construction program is imperative." The CDCR's Mental Health Program of the Division of Correctional Health Care Services, along with the DMH, participates regularly in the planning for these facilities. This court mandated collaboration has required reconfiguration of the long term mental health bed plan approved by the *Coleman* court on October 17, 2007 in order to conform to the "construction agreement" order and the design and location requirements of these facilities.

Furthermore, in June 2008, CDCR and the DMH reached agreement that the DMH would continue to provide all inpatient acute and intermediate mental health services instead of transferring responsibilities to provide those services to the CDCR. The reconfiguration of the bed plan also incorporates this decision.

Two of the Receiver's new health care facilities will accommodate the DMH inpatient acute and intermediate mental health services. These mental health programs will be operated by the DMH in collaboration with the Receiver's medical, the CDCR mental health and the CDCR/Receiver custody programs. At each facility, these four discreet but interrelated programs are proposed to be under the overall management of a Health Care Chief Executive Officer who will be the controlling administrative authority for each facility's development and operations.

In addition, the projected number and types of beds identified in the December 2006 Mental Health Bed Plan and the August 2007 Supplemental Bed Plan are based on the June 2006 Mental Health Bed Need Study – 2006 Update ("Bed Need Forecast"). The current bed plan and this response identifies projected mental health bed need based on the "Mental Health Bed Need Study – Based on Spring 2008 Population Projections, June 2008," which updates the previous plan.

B. Purpose of Report

In addition to updating the long term mental health bed plan, this report responds to the October 17, 2007, *Coleman* Court order, requiring the CDCR to submit to the *Coleman* Special Master the following plans:

- A plan for identifying anticipated clinical and custody staffing needs and a program for providing the personnel required to recruit, vet, hire and retain adequate staffing;
- A plan for the recruitment and compensation of hospital administrators to develop and run California Department of Corrections and Rehabilitation's overall inpatient treatment program and the specific institutional inpatient programs in its consolidated care centers;
- Preparation of a memorandum of understanding (MOU) on California Department of Mental Health's mentoring and direct service obligations under the revised plan for integration in an inter-agency agreement; and
- An analysis justifying the reduction and/or elimination of mental health crisis beds (MHCB) (as recommended) in the revised August 2007 plan in the 29 California Department of Corrections and Rehabilitation institutions that are not scheduled to deliver consolidated care.
- A plan with time frames for meeting and procuring for all CDCR-operated inpatient programs applicable State Licensure and Joint Commission on Accreditation of Healthcare Organizations accreditation.

The numerous proposed modifications to the August 2007 Supplemental Bed Plan, based in a variety of issues, render some of the plans requested above irrelevant or significantly altered. This document identifies the bases for the originally requested plans as well as the changes that have occurred that drive the revisions.

C. Context

There have been four elemental changes since the August 2007 Supplemental Bed Plan: the construction collaboration order which made formal the coordination of the construction of mental health beds with the Receiver; the consolidation of the acute and intermediate care beds into fewer facilities; the agreement that the DMH continue to manage and provide inpatient acute and intermediate mental health services; and the incorporation of female mental health facilities into the collaboration agreement. In addition, the coordination agreement provided for the inclusion within the Receiver's facility program, the mental health beds that were contained in the original bed plan (with few exceptions that are described later in this document) and the ability to consider the most appropriate use of beds within existing facilities.

Based on historical evidence of the existence of co-morbidity between mental illness and physical illness, there are strong patient care and fiscal incentives to plan, design and construct health care facilities that will coordinate medical and mental health treatment. The construction collaboration agreement establishes a significant change to the substance of the mental health bed plan. Instead of constructing "consolidated care centers" for mental health services only, the bed needs have now become integrated into a series of stand-alone health care facilities, California Health Care Facilities (CHCF), which will provide comprehensive medical and mental health services. While this integration supports the essential and appropriate relationship of these major health care disciplines and provides substantial economies related to their joint construction and operation, it also requires significant coordination of these elements.

As the planning for mental health services has continued to evolve, strategies for the provision of the highest levels of mental health care, inpatient acute and intermediate have changed significantly from both the December 2006 and August 2007 Bed Plans. Originally, the consolidated care centers would each have intermediate care as part of the continuum of mental health care provided in each facility. The current plan is based on the decision that the DMH continue to provide inpatient intermediate and acute mental health services, and allocates space in two of the CHCFs, one in the northern part of the state and one in the south. All inmate-patient intermediate and acute mental health services will occur in these two new facilities, thereby allowing *Coleman* court ordered state hospital beds to be returned to community use. These DMH inpatient mental health programs will be operated by the DMH in collaboration with the Receiver's medical, the CDCR mental health and the CDCR/Receiver custody programs. Furthermore, when both of these CHCFs are operational, there will be no provision of acute or intermediate levels of care outside the CHCFs.

During the evolutionary process, the female mental health bed need was incorporated into the planning of these facilities. The women's facilities would be co-located with up

to two of the men's facilities, thereby allowing for some shared services and economies of scale. In these settings, the women's facility will share a secure perimeter with the men's facility. The interior of the facility will have gender-separating sight, sound and physical barriers formed from walls naturally occurring from building--housing and treatment--space that would normally be separate even in a single gender facility. It is the task of the architects to develop a design that does this effectively and efficiently.

Construction sites and schedules for the CHCFs are still in development, with anticipation of the first 1500-bed facility targeted to begin construction in January 2009, anticipating completion by January 2011. There are eight sites being considered; land availability, infrastructure capability, environmental concerns, and political climate, among others, drive the ability to select, schedule and begin construction.

The planning for the delivery of mental health services for the CHCFs is based on the Receiver's current construction schedule and is the basis for the current plan and the response to the five issues. Once sites, facility bed configuration and construction schedules are known, a further update and status report can be provided to the Special Master. It is recommended that these status reports key on specific elements that are necessary to provide a full response to the questions: (1) projected dates for completion of each of the CHCFs; (2) the configuration of both the CDCR and the DMH mental health beds that correspond with the final planning and design for these facilities; and (3) the operational plan for the facilities, which will include the governance, administrative and clinical structure and authority of the Receiver, the CDCR and the DMH. The operational plan for the CHCFs will address licensure, the medical staff function, the role of the DMH Governing Body, pharmacy licensing and medication issues, and the overall operating process and procedures. Finally, we expect to conform the entire bed plan documentation to these determinations when they are made, which will culminate in a motion to the court requesting the formal adoption of the changes made from the current approved plan.

D. Updates/Changes

In the bed planning process, all essential elements of the August 2007 Supplemental Bed Plan are being upheld using the same methodology for determining the number and type of beds. For their programs, the CDCR will continue to plan and provide for a continuum of care within the CDCR Mental Health Program Guidelines. The CDCR remains responsible for providing the appropriate number of beds, office and treatment space for the required levels of care. However, in collaborating with the *Plata* Receiver, several specifics have changed from the August 2007 bed plan. This section of this document reflects the changes that have occurred that drive these alterations to date. Areas with updates and changes are: facility planning and locations, division of construction activities, delivery of clinical services, and population projections.

Facility Planning and Locations		
Date	Decision/Proposal	Impact
August 2007	Began informal collaboration with the Receiver regarding the design and construction of consolidated care centers.	Staff was dedicated to collaborating with the Receiver while continuing to pursue funding for the consolidated care centers should the collaboration not occur.
October 2007	The original bed plan called for five new facilities of varying size. The Receiver proposed seven facilities with approximately 1500 beds each—750 Medical and 750 Mental Health.	Required a change from the August 2007 Supplemental Bed Plan and plan for a new distribution of beds across undetermined sites. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart) Created the need to continue on two planning tracks (the normal Capital Outlay –Budget Change Proposal process and the Receiver's planning track) in order to stay in process for either eventuality.
November 2007	The five sites in the August bed plan were partially inconsistent with the Receiver's seven proposed sites. The eight sites currently proposed for consideration are: <ul style="list-style-type: none"> • Northern California Youth Center, Stockton • California State Prison (CSP) – Sacramento (SAC) • Deuel Vocational Institution, Tracy • Ventura Youth Facility • R. J. Donovan Correctional Facility (RJD) • California Institution for Men (CIM), Chino • Nellis/Whittier • California Medical Facility (CMF)/CSP-Solano 	Created a conflict with the August 2007 Supplemental Bed Plan which was crafted with specific sites on which to build consolidated care centers. The logic behind the original proposed creation of new beds at specific sites and the proposed decommissioning of mental health beds at other sites (returning them to the institution) was no longer as valid as long as different sites were proposed. Required reconfiguration of supplemental bed plan beds and a change in the bed plan chart. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)

Feb. 2008	Courts approved the "construction agreement" for collaborative "construction of approximately 5,000 additional CDCR medical beds and approximately 5,000 CDCR mental health beds." Order gave the Receiver the lead in the construction process.	Gave the Receiver the authority to lead the planning, design and construction projects for health care. Tied the CDCR construction schedules and locations to Receiver's plan.
January-June 2008	<p>Reduced number of sites planned to include Intermediate Care (ICF) beds from five identified in the August 2007 Supplemental Bed Plan to two facilities built by the Receiver's program.</p> <p>This change is to provide for all ICF and acute bed need in new facilities to accommodate the DMH's continuing provision of these services.</p>	<p>Required multiple - reconfigurations of supplemental bed plan beds and changes in the bed plan chart to reflect changing locations of ICF beds. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)</p> <p>Creates the ability to provide ICF and acute care in both northern and southern locations. Allows state hospitals to redirect beds to community care and away from inmate care. Allows for institution beds to be returned to institutional use.</p>
March 2008	Included women's beds in Receiver's CHCF projects at two locations. Women's facilities are to be built with sight and sound barriers to share some services and create economies of scale.	A larger number of beds, and therefore larger facilities, are planned for two sites: one in the North and one in the South. Required reconfiguration of bed plan chart. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)
May 2008	Redistributed 5 MHCB from Ironwood State Prison to: 1-Pleasant Valley State Prison (1 bed) and Substance Abuse Treatment Facility (4 beds)	Required reconfiguration of MHCB in bed plan chart(Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)
June 2008	Planned decommissioning of existing Enhanced Outpatient Programs (EOP) and Administrative Segregation Units (ASU) at RJD, CSP-Los Angeles County (LAC) and SVSP.	Required reconfiguration of bed plan chart to accommodate changes.

	Increased by these numbers of beds the mental health program within the Receiver's CHCF project.	Requires additional transition planning for both staff and inmate-patients.
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Division of Construction Activities		
Date	Decision/Proposal	Impact
March 2008	<p>Maintained the following projects by CDCR:</p> <ul style="list-style-type: none"> • 64-bed ICF at Salinas Valley State Prison (SVSP)/Salinas Valley Psychiatric Program (SVPP) • 64 bed ICF at CMF/Vacaville Psychiatric Program (VPP) • 50 bed MHCB at California Men's Colony (CMC) • 32 bed MHCB at San Quentin State Prison (SQ) • 50 bed MHCB at CMF • 67 EOP beds at CMF 	Required update to original bed chart to delineate between Receiver's project and CDCR's projects. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)
June 2008	<p>To accommodate agreement whereby the DMH assumes responsibility for the inpatient acute and intermediate mental health services, the CDCR has moved the new and existing ICF beds from CDCR projects (SVSP/SVPP and CMF/VPP) into the CHCF construction projects.</p> <p>Maintained the following projects to be constructed by CDCR:</p> <ul style="list-style-type: none"> • 50 bed MHCB at CMC • 32 bed MHCB at SQ • 67 EOP beds at CMF • (50-bed MHCB at CMF is activated.) 	<p>Required update to chart and placement of all ICF bed need into CHCFs. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)</p> <p>Treatment space must still be built to provide treatment until new facilities are built and activated.</p>
June 2008	Decision to move EOP programs from RJD, LAC, and SVSP into the CHCFs.	Placed more beds into the CHCFs. Allows for these beds to be returned to institutional use and eliminates the requirement for additional treatment and office space at LAC.

		Requires update to bed plan. (Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)
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Delivery of Clinical Services		
Date	Decision/Proposal	Impact
November 2007	Interpreted philosophy of behavior-based treatment and placement by replacing the Psychiatric Services Unit (PSU) and ASU with EOP-High and creating an ICF-High instead of using the current classification system	Discussion is ongoing about creating another system by which patients are placed in certain beds. This system will be clinically based and will depend on current behavior. This creates concern among custody staff that relies on the current classification system for placement. It may create the need to staff differently and create new policies and procedures.
April 2008	The Courts ordered a coordination agreement regarding the Chief Executive Officer Pilot program.	This new governance structure is expected to be incorporated into the management structure of the operational plan for the joint facilities. Requires modification of Supplemental Bed Plan regarding administrative/management structure.
June 2008	The decision for the DMH to continue to provide inpatient acute and intermediate mental health services to CDCR inmate-patients in the newly constructed health care facilities.	Required modifications to the August 2007 Bed Plan. The modifications are as follows: <ul style="list-style-type: none"> • Two new CHCFs will accommodate the DMH inpatient acute and intermediate mental health services. These mental health programs will be operated by DMH in collaboration with the Receiver's medical, the CDCR mental health and the CDCR/Receiver's custody programs. • Inmates requiring inpatient acute and intermediate mental health services removed from the DMH <i>Coleman</i> court ordered state hospital, VPP and SVPP beds and placed in new facilities. • Requires the addition of beds for inmates identified as PC1370 inmates. • Eliminates mentoring aspect of the August 2007 Supplemental Bed Plan

		<p>in that DMH will staff and run the inpatient program.</p> <ul style="list-style-type: none">• The current inpatient ICF and Acute beds at CMF/VPP and SVSP/SVPP will be put to another use. <p>(Compare Attachment A: August 2007 bed chart to Attachment B: June 2008 chart)</p> <p>Additionally an Interagency Agreement between DMH and CDCR is required to clarify and formalize the clinical services agreement.</p>
June 2008	Mental Health Staffing Workload Study Model approved.	The workload study model will provide the mechanism for appropriate clinical staffing of the Correctional Clinical Case Management System (CCCMS), EOP and MHCB levels of mental health care within CDCR..
June 2008	Activated 50-bed MHCB at CMF.	Shown as operational. (See Attachment B: June 2008 Chart.)

Population Projections		
Date	Decision/Proposal	Impact
June 2008	Mental Health Bed Need Study – Based on Spring 2008 Population Projections was published.	Required creation of bed plans with bed need projections to 2017. Alters new bed need numbers; requires reallocation of beds in Receiver's building program. (Compare August 2007 to June 2008 chart.)

E. Compilation of *Coleman* Court Orders related to the Long-term Mental Health Bed Plan

The preceding table of changes variously addresses and impacts multiple orders from the *Coleman* Court regarding the creation of mental health beds, treatment space, and office space. Attachment C of this document maps each *Coleman* court order related to creation of space by date and content; the actual and/or proposed entity with which the responsibility for providing that space lies; and the status of each of the projects emanating from the orders.

II. Specific Plans Required by the October 17, 2007 Coleman Order

A. Identifying Clinical and Custody Staffing Needs and a Program for Providing the Personnel to Recruit, Vet, Hire and Retain Adequate Staffing

Identifying Staffing Needs

Historically, the CDCR has had difficulty in obtaining adequate staffing and filling clinical vacancies within its mental health program. Initially, staffing requirements for each level of care were outlined in the Mental Health Program Guide. As long as the program guide's original assumptions remained static, the clinician to inmate-patient ratios identified were appropriate. However, as the mental health program developed and grew, and as the inmate-patient population grew with the prison population, the original assumptions began to change and the appropriateness of staffing levels was thrown into question.

In Fiscal Year 2006-2007, in order to re-establish credible and viable staffing complements, a workload study was commissioned. The completed study, called the Mental Health Staffing Workload Study – June 2007, identified actual workload and workload drivers and developed a comprehensive compendium of tasks required by level of clinical staff to fully achieve the objectives of the Mental Health Program Guide. The workload study, which proposed revised program staffing levels, and a corresponding Budget Change Proposal (BCP) requesting additional positions to support the recommendations of the workload study were submitted to the Legislature on April 1, 2008. In June 2008, the BCP was approved by the Joint Legislative Conference Committee on the Budget.

The Mental Health Staffing Workload Study – June 2007 also created a template from which future CCCMS, EOP and MHCB can be clinically staffed. The CDCR is using this study and the incorporated staffing formula for planning purposes. The level and size of treatment program, as well as the type of facility in which the program is housed, dictate the numbers and classifications of clinical and support staff required in order to be consistent with the mental health program guidelines and requirements. Projected staffing patterns are being determined through the use of the workload study formulas for the EOP and MHCB levels of care.

Under the administrative oversight of the Chief Executive Officer of the CHCF, the DMH will be responsible for operating and providing inpatient acute and intermediate mental health services in collaboration with medical, CDCR mental health and CDCR/Receiver custody programs. This requires that DMH be responsible for planning for and obtaining appropriate staffing (including Registered Nurses and Medical Technical Assistants – Psychiatric) for the respective levels of care. It is anticipated that the staffing will be similar to those already established and used by the DMH at SVPP and VPP.

Under the direction of the Receiver's office, comprehensive operational planning for these facilities has begun but has not yet been completed. Upon completion of the Operational Plan, and the establishment of firm construction locations and dates, staffing plans will be produced which include recruitment, hiring and retention planning. Custody staffing patterns for mental health operations are also being determined through joint operational planning with the Receiver.

Functional Staffing Areas

The August 2007 Supplemental Bed Plan describes a CDCR headquarters management structure in which a Deputy Director reports to the Statewide Director of Mental Health. The plan further states that the Deputy Director position (which has been established) will administer two functions: 1) the statewide development and oversight of the mental health programs in the joint facilities and 2) the statewide support of these programs. Reporting to the Deputy Director will be mental health program managers of each facility and an Assistant Deputy Director who is responsible for the statewide support function.

As part of administrative and management planning, CDCR and the Receiver have collaborated on a proposed "shared governance" agreement, whereby a health care Chief Executive Officer is to be "responsible for health care delivery systems within one or more specified institutions as a means of ensuring coordinated multi-functional services and interdisciplinary interactions within a prison that are vital to a manage care delivery system." This governance structure is expected to be incorporated into the management structure of the operational plan for the CHCFs. It is anticipated that the "shared governance" agreement will significantly alter the headquarters management structure described in the August 2007 Supplemental Bed Plan. It has yet to be determined how the separate DMH inpatient mental health programs will be integrated into the governance, administrative and management planning of the two CHCFs where the DMH has programs.

Three functional areas of the CDCR mental health program staffing are in development: (1) the headquarters-based team tasked with conceptualizing, planning, designing, developing, and ultimately, providing state-level support for the programs; (2) an Activation Team that works within the operational plan and is charged with establishing the site-specific mental health programs, and becomes the initial program management staff for particular sites and transitions to the site as activation begins; and (3) mental health staff that provide clinical and support services will be recruited, hired and assigned consistent with the joint operational plan.

There is an agreement between the CDCR and the DMH for the DMH to operate the inpatient mental health programs within the CHCFs. The DMH will develop a plan to administer and manage the inpatient acute and intermediate mental health program using and building upon the expertise it has already demonstrated. Discussions that involve joint CDCR and DMH clinical hiring and privileging processes are being planned

and the training syllabi and lesson plans for all DMH staffing needs have been developed.

Both the CDCR and the DMH headquarters management and administrative support will be developed as needed consistent with the evolving plan.

Clinical Recruitment and Retention

A major aspect of recruitment and retention planning for the CDCR mental health facility staff is the design of the program and facility for the intended purpose of health care. Clinicians want to work in settings conducive to treatment, they want to have therapeutic contact with patients, and they want clinical interventions to be supported within the residential milieu. The ability to work within an intentionally therapeutic environment will be a valuable tool in assisting with the recruitment and retention of clinicians.

In selecting the sites for the new medical/mental health facilities, the clinical candidate pool in the surrounding geographical area of the facilities is, among other concerns, a primary consideration. A pilot project to incorporate Licensed Marriage and Family Therapists into the staffing complements is currently underway. Statewide implementation of that project would create a larger recruitment pool that will help alleviate mental health clinical staffing shortages.

The CDCR is also considering methods (e.g., hiring a recruitment consultant) to train departmental recruiters and improve recruitment methods within the department. Given therapeutic facilities and programming, sufficient remuneration, and community amenities and support, mental health clinical staff is recruited by using institution-based workshops, recruitment presences at schools, universities and professional conferences in and out of state, advertisements in professional journals and any other methods that can practicably be implemented. Additionally, student and pre-licensure clinical internships and forensic/correctional curricula are under development to create and employ a pool of candidates whose primary interest is in correctional mental health. An increased and accurate web presence along with user friendly application and credentialing processes will contribute to achieving clinical recruitment goals.

The DMH shall continue to recruit using recruitment presence at schools, universities, and professional workshops. Advertisements in professional journals and publications have also helped to increase the DMH recruitment efforts. Student practica, pre-licensed internships and post-doctoral fellowships have been a valuable tool for recruitment. At the VPP and SVPP student and pre-licensure internship programs are used for clinical advancement and as a recruitment method for certain classifications. The VPP has an Accredited American Psychological Association (APA) Internship Program. The VPP and SVPP utilize Nursing Rotation programs for Registered Nurses (RN), Licensed Vocational Nurses (LVN) and Psychiatric Technicians (PT). Both Programs also have internship programs for Social Workers and Rehabilitation Therapists.

Custody Recruitment and Retention

Facility planning to date is emphasizing a "direct supervision" philosophy as the primary and overarching custody approach within the CHCFs. This approach combines line of sight architecture, a manageable and consistent inmate to officer ratio, leadership and communication competency training, and an understanding and embodiment of fairness and justice as fundamental tenets. The direct supervision philosophy has been shown over time to be cost effective by minimizing construction costs and damage repair costs. It has also been shown to be safe because officers are in positions to be proactive and resolve tension before it escalates into violence.

Discussions are in progress regarding the provision of specialized training for custody staff who work in both the CDCR mental health programs and the DMH inpatient mental health programs. With these principles at the forefront, custody staff can be recruited both from within CDCR and by using currently established successful recruitment efforts. However it has yet to be determined how the custody operations will be integrated into the separate DMH Milieu. More detail is expected to be developed through the joint operational plan.

Administrative and Support Staff Recruitment and Retention

The CDCR and the DMH headquarters and mental health administrative and support staff will be recruited from within state civil service and, wherever possible, from open examinations. The CDCR mental health staff will be hired and credentialed through the currently established processes. The DMH inpatient mental health services staff will be hired by DMH and credentialed and governed through mutually developed and agreed upon processes.

It is understood that all staff must be well trained to work in these types of facilities. The August 2007 Supplemental Bed Plan described in some detail the training and mentoring that the DMH was to provide the CDCR staff hired to work at the intermediate and acute health care facilities. The decision for the DMH, and not the CDCR, to manage and operate the intermediate and acute health care facilities, the training and mentoring of the CDCR staff by the DMH will no longer be required.

B. Recruitment and Compensation of "Hospital Administrators"

In his September 24, 2007 response to the August 2007 Supplemental Bed Plan, the Special Master identified concerns about the need to find, vet, hire and compensate qualified and experienced hospital administrators to obtain and retain licensing and accreditation for inpatient beds built and operated by the CDCR. The court then ordered the CDCR to create a plan for the recruitment and compensation of hospital administrators to develop and run the CDCR's inpatient program. As a result of the new agreement with the DMH there is now a need to create a plan for the recruitment and compensation of the DMH hospital administrators to develop and operate its inpatient mental health programs within the CHCFs.

The August 2007 Supplemental Bed Plan described a management structure with a Deputy Director, who reports to the Statewide Director of Mental Health. Each facility mental health program was proposed to have an Executive Director who would report to the headquarters Deputy Director. This management structure has changed significantly since the CDCR and the Receiver, as part of the administrative and management planning, collaborated on a proposed "shared governance" agreement. The current plan is to have a Chief Executive Officer responsible for the health care delivery in one or more specific institutions.

The Division of Correctional Health Care Services within the CDCR is in the process of creating the classification of Chief of Mental Health. The coordination of reporting responsibilities of this position in the entire context of the new facilities is being researched and is expected to be determined consistent with both the pending operational plan and the new governance structure.

Currently, the DMH employs a Career Executive Assignment (CEA) III as Executive Director and a CEA I as the Assistant Executive Director over both SVPP and VPP. Since the DMH inpatient program will be part of the CHCF facility, the DMH will need to create a plan for recruitment of Hospital Administrators to develop and manage the DMH's inpatient mental health program.

The August 2007 Supplemental Bed Plan required the inclusion of "executive personnel and staff from the CDCR...with expertise necessary to plan, direct, and manage large-scale and complex projects similar in nature to the new facilities." To that end, the CDCR has retained a consultant with decades of local, state and national expertise in the development and delivery of correctional mental health programs to lead the development, activation and delivery of the requirements of the supplemental bed plan.

The primary assumption within this plan is that the overarching concern of the court and the Special Master is that the CDCR have an adequate and appropriate management structure and expertise to successfully develop, implement and deliver mental health services within the approved bed plan concept. The August 2007 Supplemental Bed Plan stated that, "a portion of the (new facility) project team staff will be designated from existing resources, with remaining staff positions to be requested through the annual State budget process." Current efforts to create a division management team include the hiring of the consultant and the redirection of a special projects team, which includes a staff services manager and two analyst staff. This team has begun the fiscal and program planning that lays the ground work for the mental health programs in the new facilities.

C. Memorandum of Understanding for California Department of Mental Health's Mentoring and Direct Service Obligations under the Revised Plan for Integration in an Inter-agency Agreement

Within the August 2007 Supplemental Bed Plan and in response to the concerns noted in the Special Master's report, CDCR included the following:

- The DMH would continue to operate the Acute, ICF and Day Treatment Program (DTP) programs at CMF and SVSP, inclusive of new intermediate care beds to be built at each of these prisons (until such time as the CDCR is determined to be able to provide a DMH standard of care);
- The DMH will, in collaboration with the CDCR, implement the intermediate care program at SAC;
- The DMH will initially operate the intermediate care program at SAC with the CDCR continuing in a training modality, with the understanding that the operation of that program would eventually transfer to the CDCR with the DMH monitoring and, eventually, advisory only;
- The DMH would assume an oversight role in the implementation of the intermediate care beds at the other consolidated care centers and California Institution for Women (CIW); however, at California Institution for Men (CIM), DMH would initially operate the acute beds with eventual transfer to CDCR; and
- The planned acute beds would be consolidated at CIM.

With the recent decision that the DMH provide all inpatient intermediate and acute care mental health services within the new facilities, the current acute, intermediate and day treatment mental health MOUs will no longer apply. The CDCR and the DMH will develop an interagency agreement and MOUs for the ongoing coordination and collaboration for access of care to the DMH inpatient acute and intermediate programs.

D. Analysis Justifying the Reduction and/or Elimination of Mental Health Crisis Beds

The December 2006 and the August 2007 Bed Plans anticipated the construction of a 50-bed MHCB at CMC and the 50-bed MHCB at CMF. Spring 2008 population projections (including a reserve) anticipate the need for 410 MHCB statewide by 2017. The new bed plan (see Attachment B -- June 2008 bed chart) anticipates satisfaction of that bed need in new construction within CHCFs, in maintaining MHCBs disbursed statewide, in the planned construction of the CMC 50-bed facility and in the activation in June 2008 of the CMF facility.

The 50-bed MHCB at CMC was court ordered only in the circumstance that CMC would not become a site for a consolidated care center. In the August 2007 Supplemental Bed Plan, the current EOP was proposed to be eliminated because a new consolidated care center facility was proposed to be built there. It now appears that CMC is not going to be a site for a new consolidated care center or CHCF thereby requiring the construction of the 50-bed crisis facility. The new proposed bed plan anticipates leaving the current EOP at CMC as it stands. The new 50-bed crisis facility will serve the crisis needs of that EOP population and will replace the 36 bed interim facility.

The reallocation of the MHCB, as outlined in the bed plans, was designed to locate the highest levels of CDCR mental health services in specific locations and is predicated on the construction of new crisis beds at CMF, CMC and in the new facilities. New EOP beds also are planned to be located in the new facilities and, because this level of care is a high user of MHCB, the preponderance of crisis beds will be co-located there. The EOP population is, by definition, less stable than the general population (GP) and is thus more prone to crisis. However, there is also an, albeit smaller, need for crisis beds in GP institutions. It is the intention of the CDCR to have crisis beds operational throughout the state. In some institutions, the crisis beds will eventually be at a reduced level, but only when it is determined that the overall statewide need has been met elsewhere.

There is no plan to reduce any mental health crisis beds currently operational until enough additional crisis beds are available to meet need and there is no waiting list for that level of care. Careful analysis of crisis bed use, wait lists and population trends over time will inform how, when and where crisis beds will be decommissioned. As new crisis beds are built and activated, this analysis will become more critical and detailed. If a downward trend in crisis bed use to numbers of beds available is validated, a schedule for reduction will be developed. Included in any deactivation schedule will be an additional detailed review of population trends, bed use and wait lists. The Correctional Treatment Centers will remain in place and active, with only the crisis bed use considered for deactivation.

E. Timeframes for Joint Commission Accreditation for CDCR Operated Inpatient Facilities

On October 18, 2007, the *Coleman* court issued an order that in a pertinent part stated: "Defendants shall submit to the Special Master a plan with timeframes for meeting and procuring for all California Department of Corrections and Rehabilitation operated inpatient programs applicable State licensure and accreditation by the Joint Commission on Accreditation of Healthcare Organizations."

The DMH has been the CDCR's longtime contractor of inpatient acute and intermediate mental health services for both male and female inmate-patients. The August 2007 Mental Health Bed Plan indicated CDCR would assume responsibility for operating the new inpatient acute and intermediate care beds.

In June 2008, a proposal was created whereby the DMH would be responsible for managing and operating the intermediate and acute inpatient clinical services instead of transferring the operation to the CDCR. These mental health programs will be operated by the DMH in collaboration with the Receiver's medical, the CDCR mental health and the CDCR/Receiver's custody program in two of the CHCFs.

The following page is a proposed timeframe for the DMH to achieve State licensure and Joint Commission (JC) accreditation for the proposed inpatient programs.

**TIMEFRAMES FOR STATE LICENSURE AND JOINT COMMISSION
ACCREDITATION FOR THE DMH's PROPOSED ACUTE AND INTERMEDIATE
INPATIENT TREATMENT PROGRAM.**

(Adapted from the April 2008 DMH facility project overview)

Summary Task	Proposed Timeframe
Develop Operating Manuals, Staff Bi-laws, Governing Body, etc. in accordance with State and Joint Commission standards.	Approximately 2 years prior to estimated activation (Begin January 2009)
Verification of program manuals, staff orientation and training.	2010 to 2011
Completion of construction of facility and installation of equipment, supplies, furniture, staff, etc. Begin State licensing preparation.	2010 to 2011
Facility inspections, Department of Health Services' licensure.	December 2010 to January 2011
Begin patient admissions.	February 2011
Joint Commission Self Survey.	February 2011 to February 2012
Self Survey Correction, Mock Joint Commission Survey, submission of Joint Commission Application.	February 2012 to November 2012
First Joint Commission survey.	2 years status post activation (approx. November 2013 to November 2014)

Initial survey: Application for survey is valid for six months. Normally takes three-four months after receipt of application to conduct survey. Most organizations take one full year from the point of decision to be accredited until time of first survey.

III. Outline of Changes to Bed Plan Charts

Attachment A:

Entitled: Mental Health Bed Plan, December 2006 – Enclosure II (Amended)

This chart was in the December 2006 Mental Health Bed Plan and was amended for the August 2007, Supplemental Bed Plan. It uses bed need projections through 2011 based on the Mental Health Bed Need Study – 2006 Update. The intent of this chart was to show the progression from scattered mental health programs into consolidated care centers, using current planning. This chart forms the basis for the ensuing charts.

Incorporated into this chart are the following assumptions:

1) Table #1 would become fully activated and operational by 2011. This table includes several projects that were in various planning stages with funding ranging from none to through specific design stages. Specifically the chart assumed that the following projects would be constructed and activated by June 2011:

- The 50 bed MHCB at CMC;
- The treatment and office space for 150 EOP beds at LAC;
- The 64 bed ICF at SVSP;
- The 64 bed ICF at CMF; and
- The 50 bed MHCB at CMF.

2) Table #2 proposes the Consolidated Care Center locations at the following locations:

- SAC
- RJD
- CMC
- CIM
- LAC

3) Table #2 proposes the decommissioning of the following beds:

- COR: 150 EOP; 54 ASU; 23 MHCB
- MCSP: 510 EOP; 36 ASU; 3 MHCB
- CMC: 580 EOP; 54 ASU and
- MHCBs at the following locations:
 - HDSP – 5
 - KVSP – 12
 - NKSP – 5
 - SATF – 11
 - SOL – 9
 - WSP – 1
 - CIM – 18

4) The female chart assumed the construction of all new women's beds at California Institution for Women (CIW).

Attachment B:

Entitled: California Health Care Facilities--Mental Health Program--June, 2008

The "California Health Care Facilities--Mental Health Program--June, 2008" bed plan is the culmination of several iterations of bed planning. This final chart is intended to perform several functions:

- 1) To clearly delineate currently active mental health beds from bed creation projects that are not yet built or activated;
- 2) To clearly define the bed need projections in appropriate levels of care;
- 3) To identify project responsibility (i.e., which projects are proposed to be incorporated into the Receiver's "Joint Project" and which were to be maintained to be built by CDCR); and
- 4) To reflect current planning for level of care placement in CHCFs.

This chart incorporates several changes resulting in decisions made and studies finalized in June 2008:

- 1) The Mental Health Bed Need Study – Based on Spring 2008 Population Projections, June 2008 was finalized.
 - This study makes projections of the mental health population to 2017.
 - These projections, plus a "target reserve" calculated using the same method as in the August 2007 Supplemental Bed Plan, are used as the bed need.
 - This represents an increase in the bed need.
- 2) The decision for DMH to provide the inpatient acute and intermediate mental health services created several changes to the bed plan.
 - The entire Intermediate and Acute bed need will be provided in the new facilities. This means decommissioning SVSP/SVPP ICF beds and CMF/VPP Acute and ICF beds as well as the beds currently located in the DMH state hospitals.
 - Part of the decision was also to include ICF beds for inmates requiring DMH care under Penal Code 1370, individuals found by the court to be incompetent to stand trial.
 - This required major shifting of the program beds and the addition of additional beds to the Receiver's project.
- 3) In keeping with the court order to build the 50-bed MHCB at CMC, the EOP beds will remain active at CMC.
 - The EOPs at LAC, RJD, and SVSP will be decommissioned (as well as those at Mule Creek State Prison, and CSP – Corcoran, which were identified to be decommissioned in the August 2007 Supplemental Bed Plan).
 - This required major shifting of the program sites and a reconfiguration of the beds in the Receiver's project.

Attachment B (continued)

From left to right the "California Health Care Facilities--Mental Health Program--June, 2008" bed plan reads as follows:

- 1) Table #A reflects the actual beds in operation as of June, 2008.
- 2) Table #B reflects new beds proposed to be built.
 - Clearly separates Joint Project beds from CDCR beds: yellow represents the Joint Project beds; black represents those retained by the CDCR.
 - Alters the original locations of CCCs to unnamed sites to be considered CHCFs.
 - Alters the plan from building ICF beds in all sites to building two sites with ICF and acute beds: one in the northern part of the state and one in the south.
- 3) Table #C reflects the proposed beds to be decommissioned.
- 4) Table #D reflects the total beds at each site after construction and activation of the supplemental bed plan beds.
- 5) The Female chart reflects the decision to incorporate the female mental health bed need into the Receiver's Joint Project, placing the female beds in two sites – one north and one south.

IV. Summary

This Bed Plan is subject to the receipt of funding by the *Plata* Receiver necessary for the design and construction of his planned 1500-bed Correctional Health Care Facilities.

The culmination of this evolving process and the coordination with the Receiver's office has resulted in a greatly improved bed plan for the provision of mental health services to inmate-patients. It provides a very real opportunity to provide improved services to mental health treatment population that complies with the requirements of the program and the court.

California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 - Enclosure II (Amended¹)

MALES

Introduction: As a general rule, the following proposal uses existing beds at five (5) Consolidated Care Center (CCC) sites* (the CCC sites are SAC, RJD, CMC, CIM, and LAC), plus at SVSP and CMF, and proposes to build additional capacity to meet and exceed Navigant's projected mental health bed need for June 2011, (based upon Spring 2006 population projections).

PROPOSAL - Assumes that the CDCR will operate the Acute and ICF programs and that there is no bed capacity at DMH hospitals (i.e. no beds at ASH, CSH, Napa, or Metro).

INITIAL
Expected Permanent Bed Capacity, June 2011
NO NEW BEDS
(Status Quo)

New Beds to be Constructed
+ Reduction of Existing Beds

FINAL
Expected Permanent Bed Capacity
WITH CONSTRUCTION OF NEW BEDS
Post Implementation of Mental Health Bed Plan, December 2006
(Proposal)

Table #1: Number of permanent mental health beds anticipated in June 2011** with no construction of additional beds, (except where noted).

Institution	Level of Care					ICF- High Custody	Total
	EOP	ASU	PSU	MHCBS	Acute		
SAC	384	124	192	24			724
RJD	330	63	14				407
CMC ¹	580	54	50				684
CIM			18				18
LAC ²	450	54	12				516
SVSP ³	192	45	10			128	375
CMF ⁴	600	58	50	150	84	64	1,006
PPSP ⁵	64		128	10			202
Sub-Total:	2,600	398	320	188	150	84	3,932
COR	150	54	23				227
MCSP	510	36	8				554
SQ		36	32				68
HDSP			10				10
ISP			5				5
KVSP			12				12
NKSP			10				10
PVSP			5				5
SAIF			16				16
SOL ⁶			9				9
WSP			6				6
Sub-Total:	660	126	0	135			922
Grand Total:	3,260	524	320	324	150	84	4,854
Navigant Bed Need, June 2011 ¹⁴							
Beds Deficient (Bed Need - Grand Total Beds Table #1)							1,452

* Note: will not use existing EOP, ASU, or MHCBS at CMC and CIM.
** Data sources for number of beds: Health Care Placement Unit, Licensing Unit, and Office of Facilities Management.
1 Assumption: CMC - The 50 bed MHCBS project proposed in the Interim ICF and MHCBS Plan, June 2006 will be constructed.
2 Assumption: LAC - The 150 bed EOP project as proposed in the April 2006 plan will be constructed.
3 Assumptions: SVSP - 1. The 64 bed ICF project will be constructed.
2. All 128 ICF beds are counted as High Custody.
4 Assumptions: CMF - 1. ICF: The 64 bed ICF facility as proposed in the April 2006 plan will be constructed.
2. EOP: The 30 temporary ICF beds at P-3 will be returned to 67 EOP beds.
3. MHCBS: The 50 bed MHCBS unit is constructed.
5 PPSP: 4 of the 10 MHCBS are not covered under budgeted staffed positions. Covered under registry or overtime.
6 SOL: CTC can treat only 8 MHCBS patients because of physical plant issues.

The Supplemental Bed Plan Report - August 2007 amends the December Bed Plan - 2006. Modifications to the original December Bed Plan - 2006 Enclosure II are underlined and shaded.
August 17, 2007

Table #2: Estimated number of new permanent beds to be constructed by June 2011, and reduction of existing permanent beds to meet the bed deficiency in Table #1.

Institution	Level of Care					ICF- High Custody	Total
	EOP	ASU	PSU	MHCBS	Acute		
SAC	336		26				432
RJD	390	62	128	16			666
CMC ¹	720	125	128				1,043
CIM ²	720	125		30	90		1,035
LAC ³	270	71		38			449
SVSP ⁴	96	70					166
CMF							0
PPSP ⁵							0
Sub-Total:	2,532	453	256	110	90	230	3,791
COR	-150	-54		-23			-227
MCSP	-510	-36		-3			-549
SQ		-36					-36
HDSP				-5			-5
ISP							-5
KVSP				-12			-12
NKSP				-5			-5
PVSP				-11			-11
SAIF				-9			-9
SOL				-1			-1
WSP							-1
CMC	-580	-54					-634
CIM				-18			-18
SVSP ⁶	-45						-45
Sub-Total:	-1,240	-225	0	-87			-1,552
Grand Total:	1,292	228	256	23	90	230	2,239

1 Assumption: CMC not using existing EOP and ASU population facilities, and the 50 bed MHCBS unit is constructed see Table #1, footnote #1.
2 Assumption: CIM not using the existing 18 GACH acute psych. beds as MHCBS. Total equals all new beds.
3 Assumption: SVSP - The 128 bed ICF facility as proposed in the Statewide Mental Health Bed Plan, April 2006 will be re-opened to construct a 70 bed EOP-ASU, and will convert existing space at SVSP to accommodate an additional 66 EOP beds.
4 Assumption: SVSP - The current 45 ASU beds will be included in the proposed new 70 bed EOP-ASU construction project.
5 Note: Does not include the return of temporary beds, (i.e., 35 MHCBS at CMC, 112 ICF beds at SVSP, and 36 ICF beds at CMF P-3).

Adjustment - Add Reserve¹⁴ from Table #3: 787
Bed Deficiency Adjusted for Reserve: 2,239

Table #3: Number of permanent mental health beds anticipated through construction of new beds.

Institution	Level of Care					ICF- High Custody	Total
	EOP	ASU	PSU	MHCBS	Acute		
SAC	720	124	192	50			1,156
RJD	720	125	128	30			1,073
CMC	720	125	128	50			1,093
CIM	720	125		30	90		1,035
LAC	720	125		50			965
SVSP	288	70		10			496
CMF	600	58		50	150	84	1,006
PPSP ⁵	64		128	10			202
Sub-Total:	4,552	752	576	280	240	312	6,266
COR							0
MCSP				5			5
SQ				32			32
HDSP				5			5
ISP				5			5
KVSP							0
NKSP				5			5
PVSP				5			5
SAIF				5			5
SOL							0
WSP				5			5
Sub-Total:				67			67
Grand Total:	4,552	752	576	347	240	312	7,093
Navigant-A 4,175 675 401 268 224 16 15 48 63							
Reserve-A 377 77 175 79 16 15 48 63							
% Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%							

** The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
** Source: Mental Health Bed Need Study - 2008 Update, Navigant Consulting, June 2008.
14 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
15 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
16 Navigant-A 4,175 675 401 268 224 16 15 48 63
17 Reserve-A 377 77 175 79 16 15 48 63
18 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
19 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
20 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
21 Navigant-A 4,175 675 401 268 224 16 15 48 63
22 Reserve-A 377 77 175 79 16 15 48 63
23 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
24 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
25 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
26 Navigant-A 4,175 675 401 268 224 16 15 48 63
27 Reserve-A 377 77 175 79 16 15 48 63
28 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
29 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
30 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
31 Navigant-A 4,175 675 401 268 224 16 15 48 63
32 Reserve-A 377 77 175 79 16 15 48 63
33 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
34 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
35 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
36 Navigant-A 4,175 675 401 268 224 16 15 48 63
37 Reserve-A 377 77 175 79 16 15 48 63
38 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
39 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
40 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
41 Navigant-A 4,175 675 401 268 224 16 15 48 63
42 Reserve-A 377 77 175 79 16 15 48 63
43 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
44 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
45 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
46 Navigant-A 4,175 675 401 268 224 16 15 48 63
47 Reserve-A 377 77 175 79 16 15 48 63
48 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
49 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
50 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
51 Navigant-A 4,175 675 401 268 224 16 15 48 63
52 Reserve-A 377 77 175 79 16 15 48 63
53 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
54 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
55 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
56 Navigant-A 4,175 675 401 268 224 16 15 48 63
57 Reserve-A 377 77 175 79 16 15 48 63
58 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
59 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
60 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
61 Navigant-A 4,175 675 401 268 224 16 15 48 63
62 Reserve-A 377 77 175 79 16 15 48 63
63 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
64 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
65 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
66 Navigant-A 4,175 675 401 268 224 16 15 48 63
67 Reserve-A 377 77 175 79 16 15 48 63
68 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
69 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
70 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
71 Navigant-A 4,175 675 401 268 224 16 15 48 63
72 Reserve-A 377 77 175 79 16 15 48 63
73 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
74 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
75 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
76 Navigant-A 4,175 675 401 268 224 16 15 48 63
77 Reserve-A 377 77 175 79 16 15 48 63
78 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
79 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
80 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
81 Navigant-A 4,175 675 401 268 224 16 15 48 63
82 Reserve-A 377 77 175 79 16 15 48 63
83 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
84 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
85 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
86 Navigant-A 4,175 675 401 268 224 16 15 48 63
87 Reserve-A 377 77 175 79 16 15 48 63
88 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
89 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
90 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
91 Navigant-A 4,175 675 401 268 224 16 15 48 63
92 Reserve-A 377 77 175 79 16 15 48 63
93 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
94 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
95 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
96 Navigant-A 4,175 675 401 268 224 16 15 48 63
97 Reserve-A 377 77 175 79 16 15 48 63
98 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
99 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
100 Spring 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:
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122 Reserve-A 377 77 175 79 16 15 48 63
123 % Reserve: 9.0% 11.4% 43.6% 29.5% 7.1% 5.0% 18.2% 11.2%
124 The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.
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**California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 - Enclosure II (Amended*)**

Attachment A

MALES

Table 4A: Actual vs. Target Reserve: The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed.

Table 4A: Indicates how the target reserve was calculated using the percent increase in projected populations for the years indicated in the Spring 2006 Navigant Study as minimums and maximums and calculating a target reserve based on the midpoint of the two.*

Table 4B: Indicates actual reserve for the proposal along with the difference between the actual and the target reserve.*

Table 4.A:	Minimum						Midpoint	Table 4.B:			
	Navigant Spring 2006: Projected Population By Year and Percent Increase						Target % Reserve	Actual Reserve for Proposal			Difference Between Actual and Target Reserve
	2010	2011	%	2007	2011	%		Actual % Reserve	Actual Reserve		
EOP	4,123	4,175	1%	3,672	4,175	14%	7.5%				
ASU	666	675	1%	572	675	18%	9.7%	65			
PSU	390	401	3%	332	401	21%	11.8%	47			
MHC	266	268	1%	252	268	6%	3.6%	10			
Acute	222	224	1%	203	224	10%	5.6%	13			
ICF	294	299	2%	267	299	12%	6.8%	20			
ICF (High Custody)	261	264	1%	197	264	34%	17.6%	46			
							Total:		513		

Table 4.B:				Difference Between Actual and Target Reserve
Actual % Reserve	Actual Reserve			
9.0%	377	65		
11.4%	77	12		
43.6%	175	128		
29.5%	79	69		
7.1%	16	3		
5.0%	15	-5		
18.2%	48	2		
Total:	787	274		

Differences in the reserve numbers in Table 4.A. and Table 4.B are due to rounding.

* Differences in the reserve numbers in Table 4A, and Table 4B are due to rounding.

California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 - Enclosure II (Amended)

MALES

LIST OF ACRONYMS (Arranged in Alphabetical Order)	
ASH	Atascadero State Hospital - DMH (Male)
ASU	Administrative Segregation Unit
CCC	Consolidated Care Center
CCCR	California Department of Corrections and Rehabilitation
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
COR	California State Prison - Corcoran
CSH	Coalinga State Hospital - DMH (Male)
CTC	Correctional Treatment Center
DHS	Department of Health Services
DMH	Department of Mental Health
DOF	Department of Finance
DPA	Department of Personnel Administration
DTP	Day Treatment Program
DVI	Deuel Vocational Institution
EOP	Enhanced Outpatient Program
GACH	General Acute Care Hospital Bed
HDSP	High Desert State Prison
ICF	Intermediate Care Facility
ISP	Ironwood State Prison
KVSP	Kern Valley State Prison
LAC	California State Prison - Los Angeles County
MCSP	Mule Creek State Prison
MHCB	Mental Health Crisis Bed
NKSP	North Kern State Prison
PBSP	Pelican Bay State Prison
PSH	Patton State Hospital - DMH (Female)
PSU	Psychiatric Services Unit
PVSP	Pleasant Valley State Prison
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison - Sacramento
SATF	Substance Abuse Treatment Facility at Corcoran
SOL	California State Prison - Solano
SQ	California State Prison San Quentin
SVSP	Salinas Valley State Prison
WSP	Wasco State Prison

California Department of Corrections and Rehabilitation

Mental Health Bed Plan, December 2006 Enclosure III (Corrected*)

FEMALES

Introduction: The following proposal uses existing beds at female institutions, and proposes to build additional capacity to meet and exceed the mental health bed need for June 2011 as projected by Navigant, (based upon Spring 2006 population projections).

PROPOSAL - Assumes that the CDCR will operate the Acute and ICF programs and that there will be no bed capacity at DMH hospitals, (i.e. no beds at PSH).

INITIAL
Expected Permanent Bed Capacity, June 2011
NO NEW BEDS
(Status Quo)

Table #1: Number of permanent mental health beds anticipated in June 2011** with no construction of additional beds, (except where noted).

Institution	Level of Care					Total
	EOP	ASU	PSU	MHCB	ICF	
CCWF	54			12		66
CW	75		20	10	25	130
VSPW		9				9
Total:	129	9	20	22	25	205

Navigation Bed Need, June 2011:	345
Beds Deficient (Bed Need - Total Beds Table #1):	140
Adjustment - PSU beds not projected and added back to:	20
Total Bed Deficiency with Adjustment (20 PSU Beds + Beds Deficient):	160

** Data sources for number of beds: Health Care Placement Unit, Licensing Unit, and Office of Facilities Management.

* Assumptions: CW - 1. The 25 bed Acute/ICF facility proposed in the April 2006 plan will be constructed.
Note if this proposal is approved, this project will require a scope change to include the MHCB and Acute/ICF beds in Table #2.
2. The 20 bed PSU project is completed.

PROPOSAL
New Beds to be Constructed

Table #2: Estimated number of new permanent beds to be constructed by June 2011 to meet the bed deficiency in Table #1.

Institution	Level of Care					Total
	EOP	ASU	PSU	MHCB	ICF	
CCWF						0
CW*	168	15		3	17	203
VSPW						0
Total:	168	15	0	3	17	203

Bed Deficiency Table #1:	160
Adjustment - Add Reserve ** from Table #3:	43
Bed Deficiency Adjusted for PSU beds and Reserve:	203

* Assumptions: CW - 1. EOP and ASU - New beds through conversion of existing space.
2. Acute/ICF and MHCB - 20 new beds will be added to the 25 bed Acute/ICF project proposed in the April 2006 plan.

FINAL
Expected Permanent Bed Capacity, June 2011
WITH CONSTRUCTION OF NEW BEDS
Post Implementation Mental Health Bed Plan, December 2006
(Proposal)

Table #3: Number of permanent mental health beds anticipated through construction of new beds.

Institution	Level of Care					Total
	EOP	ASU	PSU	MHCB	Acute/ICF	
CCWF	54			12		66
CW	243	15	20	13	42	333
VSPW		9				9
Total:	297	24	20	25	42	408

Navigation:	262	22	N/A	22	39	345
Reserve:	35	2		3	3	43
% Reserve:	13.4%	9.1%		13.6%	7.7%	

* Source: Mental Health Bed Need Study - 2006 Update, Navigant Consulting, June 2006.

** The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.

SPRING 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:

	EOP	ASU	PSU	MHCB	Acute/ICF	Total
Navigation:	336	27	N/A	16	33	412
Reserve:	30	3		9	9	51
% Reserve:	11.6%	11.1%		56.3%	27.3%	

** Forecasted need - Planned Beds + Reserve. Source: Mental Health Bed Need Study - Based on Spring 2007 Population Projections, Navigant Consulting, July 2007.

* This document corrects a typographical error noted in the original Mental Health Bed Plan - December 2006 Enclosure III and provides an updated forecasted bed need. Corrections are limited to the PSU Table #3 with all changes underlined and shaded.

**California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 Enclosure III (Corrected*)**

FEMALES

Table 4A: Actual vs. Target Reserve: The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed.

Table 4.A: Indicates how the target reserve was calculated using the percent increase in projected populations for the years indicated in the Spring 2006 Navigant Study as minimums and maximums and calculating a target reserve based on the midpoint of the two.*

Table 4.B: Indicates actual reserve for the proposal along with the difference between the actual and the target reserve.*

Table 4.A:	Minimum				Midpoint		Table 4.B:			
	Navigant Spring 2006: Projected Population By Year and Percent Increase				Target % Reserve	Target Reserve	Actual Reserve for Proposal		Difference Between Actual and Target Reserve	
	2010	2011	%	%			Actual % Reserve	Actual Reserve		
EOP	256	262	2%	211	262	24%	13.4%	35	0	
ASU	21	22	5%	19	22	16%	9.1%	2	0	
MHCB	22	22	0%	17	22	29%	13.6%	3	0	
Acute/ICF	39	39	0%	34	39	15%	7.7%	3	0	
	Total:				7.4%	43		43	0	

* Differences in the reserve numbers in Table 4.A and Table 4.B are due to rounding.

California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 Enclosure III (Corrected*)

FEMALES

LIST OF ACRONYMS (Arranged in Alphabetical Order)	
ASH	Atascadero State Hospital - DMH (Male)
ASU	Administrative Segregation Unit
CCC	Consolidated Care Center
CCWF	Central California Women's Facility
CCCR	California Department of Corrections and Rehabilitation
CIM	California Institution for Men
CIW	California Institution for Women
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CMF	California Medical Facility
COR	California State Prison - Corcoran
CSH	Coalinga State Hospital - DMH (Male)
CTC	Correctional Treatment Center
DHS	Department of Health Services
DMH	Department of Mental Health
DOF	Department of Finance
DPA	Department of Personnel Administration
DTP	Day Treatment Program
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HDSP	High Desert State Prison
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PBSP	Pelican Bay State Prison
PSH	Patton State Hospital - DMH (Female)
PSU	Psychiatric Services Unit
PVSP	Pleasant Valley State Prison
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison - Sacramento
SATF	Substance Abuse Treatment Facility at Corcoran
SQL	California State Prison - Solano
SQ	California State Prison - San Quentin
SVSP	Salinas Valley State Prison
VSPW	Valley State Prison for Women
WSP	Wasco State Prison

CONFIDENTIAL - Spring 2008 Projections through 2017

Bed Need Source: Mental Health Bed Need Study - Spring 2008 **Portland Publications June 2008**

	EDP	EDP-MAP	MHCB	ACMA	ICF-High Country	ICF-High Country
Site 1	185	49	0	24	122	148
Site 2	375	100	0	24	0	0
Site 3	375	100	0	24	0	459
Site 4	375	100	0	24	0	269
Site 5	375	100	0	24	0	459
Site 6	375	100	0	24	122	148
Site 7	375	100	0	24	0	459
Site 8	375	100	0	24	0	459
Site 9	375	100	0	24	0	459
Site 10	375	100	0	24	0	459
Site 11	375	100	0	24	0	459
Site 12	375	100	0	24	0	459
Site 13	375	100	0	24	0	459
Site 14	375	100	0	24	0	459
Site 15	375	100	0	24	0	459
Site 16	375	100	0	24	0	459
Site 17	375	100	0	24	0	459
Site 18	375	100	0	24	0	459
Site 19	375	100	0	24	0	459
Site 20	375	100	0	24	0	459
Site 21	375	100	0	24	0	459
Site 22	375	100	0	24	0	459
Site 23	375	100	0	24	0	459
Site 24	375	100	0	24	0	459
Site 25	375	100	0	24	0	459
Site 26	375	100	0	24	0	459
Site 27	375	100	0	24	0	459
Site 28	375	100	0	24	0	459
Site 29	375	100	0	24	0	459
Site 30	375	100	0	24	0	459
Site 31	375	100	0	24	0	459
Site 32	375	100	0	24	0	459
Site 33	375	100	0	24	0	459
Site 34	375	100	0	24	0	459
Site 35	375	100	0	24	0	459
Site 36	375	100	0	24	0	459
Site 37	375	100	0	24	0	459
Site 38	375	100	0	24	0	459
Site 39	375	100	0	24	0	459
Site 40	375	100	0	24	0	459
Site 41	375	100	0	24	0	459
Site 42	375	100	0	24	0	459
Site 43	375	100	0	24	0	459
Site 44	375	100	0	24	0	459
Site 45	375	100	0	24	0	459
Site 46	375	100	0	24	0	459
Site 47	375	100	0	24	0	459
Site 48	375	100	0	24	0	459
Site 49	375	100	0	24	0	459
Site 50	375	100	0	24	0	459
Site 51	375	100	0	24	0	459
Site 52	375	100	0	24	0	459
Site 53	375	100	0	24	0	459
Site 54	375	100	0	24	0	459
Site 55	375	100	0	24	0	459
Site 56	375	100	0	24	0	459
Site 57	375	100	0	24	0	459
Site 58	375	100	0	24	0	459
Site 59	375	100	0	24	0	459
Site 60	375	100	0	24	0	459
Site 61	375	100	0	24	0	459

Attachment B - June 25 bed plan.xls
June 25, 2008

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
Mental Health Program
Coleman Court-ordered Construction
CONFIDENTIAL

Attachment C

Date Court Ordered	Plan Name	Inst	Program	Status	Responsible Party	Comments
2006-0502	April 2006 - Long Term Bed Plan	CMC	36 Crisis Beds - Building 7 LOU Conversion Modules (renovation of existing space)	Aug 07- June 08	CDCR	Construction completed. Activation in process.
2007-0201		CMF	Renovate 124 cells in Q1-3 and S2 Wings	April 08 - Aug 09	CDCR	Project pending full activation of the MHCB per request of the Coleman Special Master.
2007-0301		MCSP	Temporary EOP treatment space	Apr 08 - Oct 08	CDCR	Activation anticipated October 2008. On schedule.
2007-0514		SW Renovation ASU	Intake cells (340 stand alone and 66 non stand alone) @ 33 prisons	Nov 07 - Sept 08	CDCR	Completion targeted for September 2008. On schedule.
2007-1018	August 2007 Supplemental Bed Plan	SVSP	Construction of 6 additional group rooms (renovation) for Temporary ICF in D5/D6	FY 2010/11	CDCR	Funding for Preliminary Plans and Working Drawings are included in the 2008-09 Governor's Budget.
2007-1018	August 2007 Supplemental Bed Plan	CIW	20-Bed PSU	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2007-1018	August 2007 Supplemental Bed Plan	CIW	45 Bed Acute Care / ICF	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2007-1018	August 2007 Supplemental Bed Plan	CMF	64-Bed ICF (New stand alone)	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2007-1018	August 2007 Supplemental Bed Plan	LAC	150 EOP	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2007-1018	August 2007 Supplemental Bed Plan	SVSP	70-Bed EOP/ASU (New stand alone)	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2007-1018	August 2007 Supplemental Bed Plan	SVSP	96-bed EOP	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2007-1018	August 2007 Supplemental Bed Plan	CMF	600 EOP/58 ASU Office and Treatment space	To be determined	CDCR	A 30-day letter is being prepared to request AB 900 funding.
2007-1018	August 2007 Supplemental Bed Plan	CMF	50 Mental Health Crisis Beds (New stand alone)	5/06 - 4/08	CDCR	This project is complete and is being activated.
2007-1018	August 2007 Supplemental Bed Plan	SAC	192 EOP Treatment space (renovation office & treatment space)	FY 2010/11	CDCR	July 2007 PWB submittal for approval of Preliminary Plans was reviewed by Control Agencies who raised concerns regarding scope and cost. Upon further review, CDCR has determined project was over programmed (should have only been programmed for 192 in lieu of 384) and is developing a budget package to re-scope the project. Funding for preliminary plans is included in the 2008-09 Governors Budget.
2007-1018	August 2007 Supplemental Bed Plan	SVSP	64-Bed mental Health ICF (New stand alone)	4/07 - 11/08	CDCR	Completion of construction is targeted for November 2008.
2008-0226	Coordination Order	SAC, CIM, LAC, RJD, CMC	Long-term new bed need	Pending	Receiver	This bed-need is proposed to be incorporated into the CDCR/Receiver CHCF project.
2008-0226	August 2007 Supplemental Bed Plan	CMC	50 Mental Health Crisis Beds (New stand alone 50-bed)	To be determined	CDCR	2007 Budget Act authorizes funding this project from AB 900 if the Department of Finance certifies that the Coleman court has resolved to construct this facility rather than the proposed larger Consolidated Care Center at this same prison. The current mental health program is now proposed to remain at CMC.

Attachment D

LIST OF ACRONYMS (Arranged in Alphabetical Order)	
ASH	Atascadero State Hospital - DMH (Male)
ASU	Administrative Segregation Unit
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CIW	California Institution for Women
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EOP	Enhanced Outpatient Program
DHS	Department of Health Services
DCHCS	Division of Correctional Health Care Services
DMH	Department of Mental Health
DOF	Department of Finance
DPA	Department of Personnel Administration
DTP	Day Treatment Program
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EOP	Enhanced Outpatient Program
GACH	General Acute Care Hospital Bed
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MCSP	Mule Creek State Prison
MHCB	Mental Health Crisis Bed
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NSH	Napa State Hospital
PBSP	Pelican Bay State Prison
PSH	Patton State Hospital - DMH (Female)
PSU	Psychiatric Services Unit
PVSP	Pleasant Valley State Prison
PWB	Public Works Board
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison - Sacramento
SATF	Substance Abuse Treatment Facility at Corcoran
SOL	California State Prison - Solano
SQ	California State Prison San Quentin
SVSP	Salinas Valley State Prison
SW	Statewide
WSP	Wasco State Prison

EXHIBIT G

Dodd, Martin

From: Dodd, Martin
Sent: Friday, August 01, 2008 4:15 PM
To: 'Michael W. Bien'
Cc: 'Coleman Team - RBG Only'; 'Donald Specter'; 'Rebekah Evenson'; 'Sara Norman'; 'Hardy, Alison (EXTERNAL)'; 'Lisa Tillman'; 'Paul B. Mello'
Subject: RE: Deposition of Victor Brewer in 3-judge panel proceeding
Importance: High

Michael:

Thanks for getting back to me. I know you are busy. At the outset, let me be clear about what our concerns were and are: Judge Henderson has made it clear on more than one occasion that he doesn't want inquiry into the **Receiver's** work product and by that we mean his deliberations and considerations in the course of preparing his remedial planning before they are finalized and ready to be shared with the court as his "plan." And if discovery from the Receiver directly is off limits, then discovery from the Receiver indirectly is off limits as well. We are quite confident Judge Henderson would agree. While it is true that the 10,000 bed project has been discussed in general terms, we had concerns about how granular the questioning might become in view of the fact that the plans are still in the development stage. You can no doubt appreciate that, given the very high profile of the Receivership, particularly in the current economic and political climate, it could be damaging to the Receiver's efforts if inaccurate or incomplete information about what the Receiver may undertake was made public. I hope this clarifies our position.

We believe that your suggestion for resolving this issue in the short term is a good one. So, we are requesting, and understand that you will agree, that "for the time being" any information that Mr. Brewer may share about the 10,000 bed plan in the course of his deposition should be considered "confidential information" under the Coleman/Plata protective orders. We appreciate your willingness to accommodate the Receiver in this regard without the need for judicial intervention. **Please confirm by return e-mail that your plaintiffs' counsel in both cases are in agreement. By copy of this e-mail I am requesting that counsel for the defendants in both cases also agree to your suggestion and ask that they confirm by e-mail this afternoon.**

I think it would be a good idea if counsel for the parties and the Receiver had a discussion within the next couple of weeks to confer as to whether and when Mr. Brewer's deposition will no longer be subject to the protective order as well as how to handle future depositions that may implicate the Receiver's work product. I understand that you are scheduled to meet with Mr. Hagar in the not too distant future to get an update on the Receiver's plans. That might also be an appropriate time to discuss the discovery issues.

Once again, thank you for your efforts to resolve this matter.

Martin H. Dodd
 Futterman & Dupree LLP
 160 Sansome Street, 17th Floor
 San Francisco, CA 94104

martin@dfdlaw.com
 415/399-3841 | fax: 415/399-3838

EXHIBIT H

Dodd, Martin

From: Dodd, Martin
Sent: Thursday, August 14, 2008 10:00 AM
To: 'Michael W. Bien'; Alison Hardy; 'Donald Specter'; 'Lisa Tillman'; 'Paul B. Mello'
Cc: John Hagar
Subject: Receiver's facility plans

I understand that some or all of you met with John Hagar yesterday and he provided you with copies of the draft facilities plan that the Receiver is developing. I also understand, and this is to confirm, that the document is to be deemed confidential under the existing protective order and not subject to public disclosure. If anyone intends to file the document with the court, you will provide advance notice to the Receiver. If my understanding is incorrect, please let me know at your earliest convenience.

Martin H. Dodd
Futterman & Dupree LLP
160 Sansome Street, 17th Floor
San Francisco, CA 94104

martin@dfdlaw.com
415/399-3841 | fax: 415/399-3838

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